Papillon Gender Wellness Center
18 Village Row
New Hope, PA 18938
(215) 693-1199 (215) 693-1197fax
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Confidential Application

Legal Name____

Preferred Name ______________________________SS# _______________________

DOB _______________Address____

City ____ Zip________________________

Country_______________________________________State________________________

Home Phone____________________________Cell________________________________

E-mail _______________________________Occupation____________________________

Employer____

Emergency Contact Name/Relationship____

Emergency Contact #

Insurance Carrier____

Address______________________________________City_________________________

Zip______________Country______________________State_________________________

Phone__________________Fax____________________Plan__________________________

Expiry________________ID#______________________Policy#________________________

Subscriber's Name

ALLERGIES: ____

____

Primary Care Provider Info

Name & Title____

Phone________________**Fax**__________________**Email**______________________________

Address____

Primary Therapist Info

Name & Title____

Phone____________________ **Fax**______________________ **Email**___________________________________

Address____

Patient Info

Age_______**Height**_________________**Weight**____________**BMI**__________**Do you smoke?**______________

What services are you interested in?

___Vaginoplasty	___Eyelid Surgery	___ Voice Therapy
___Labiaplasty	___Face lift	___Trachea Shave
___Facial Feminization	___Abdominoplasty	___ Fertility
___ Breast Augmentation	___Liposuction/Contouring	___Revision Surgery
___Orchiectomy	___Electrolysis	___Workplace Seminar
___FtM Bottom Surgery	___ Rhinoplasty	___Gender Counseling
___FtM Chest Surgery	___Lip/Facial Filler/Botox	___Permanent Make-up/Scar Camouflage
___Hysterectomy	___Scrotoplasty	___Hormone Therapy

Other____

If seeking surgery, what month/year?

List **ALL** medications, hormones or vitamins that you are taking routinely

Drug	Strength	Frequency

List **ALL** Past and Present Medical Conditions

___Ulcer

___Diabetes

___Asthma or Wheezing

___Hernia

___Bleeding Disorder

___Cold Sores

___Tobacco Use

___Substance Abuse

___Heavy Snoring/Sleep Apnea

___High Blood Pressure

___Frequent Heartburn or Reflux

___Blood Clot

___Previous Hormone Use or Experimentation

___FtM Breast Binding

___Heart Murmur that has required medication

___Any Other Heart Problem____

___Broken Bones____

___Prostate or Urination Difficulty____

___Sexually Transmitted Infection____

___High Cholesterol or Triglycerides

Any other health problems not previously listed____

____

____

List **ALL** Previous Surgeries/Surgeon/Year

____

____

____

____

____

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____

List **ANY** Hospitalizations other than Surgery

____

____

____

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List **ANY** Health Problems of Family Members

____Adopted

Mother____

Is she living? _____________What is/was her age?___________________

Father____

Is he living? _____________What is/was his age?___________________

Do any family members have a history of the following?

___Diabetes Which Relative?________________________

___Stroke Which Relative?________________________

___Prostate Cancer Which Relative?________________________

___ GLBT? Which Relative?________________________

___Heart Attack Which Relative?________________________

___Breast Cancer Which Relative?________________________

___Psych Issues Which Relative?________________________

___Abnormal Bleeding or Blood Clots Which Relative?________________________

___Female Cancers (uterus, cervix, ovaries) Which Relative?________________________

Health Maintenance Record

Please list the approximate date of any of the following tests you have had, as well as any abnormalities detected.

	YEAR	RESULT
___PAP smear	_______________	______________________________
___Mammogram	_______________	______________________________
___PSA (Prostate)	_______________	______________________________
___Chest X-ray	_______________	______________________________
___Pelvic Ultrasound	_______________	______________________________
___Cholesterol	_______________	______________________________
___EKG	_______________	______________________________
___Stress Test	_______________	______________________________
___Colonoscopy	_______________	______________________________
___Monthly Self Breast Exam		____yes ____no
___Rectal Exam	_______________	______________________________
___HIV test	_______________	______________________________
___Hepatitis C	_______________	______________________________

Check if you take the following on a daily basis? Aspirin Multi-vitamin Calcium

Research and Mentoring

*Would you be willing to speak with other patients who are having a similar procedure/service to help them understand what to expect? (i.e. pain level, time for recovery, overall satisfaction) ____yes ____no

*May we use pictures of your surgery (not to include your face) on our website to help others understand post-operative outcomes? ____yes ____no

*May we include pictures of any facial surgery? ____yes ____no

*Under **complete anonymity**, may we use your patient data to further Trans-Research? ____yes ____no

Initial Intake submissions, emails and/or telephone requests **do not establish a Doctor/Patient relationship** and should not to be mistaken as such. This form is meant to expedite your appointment and will not be reviewed by Dr McGinn until the time of your consultation. I attest that the information in the previous five pages is accurate.

____

Print Legal Name Legal Signature or X Date